Certification of Completion/Delivery of HCBS STAR+PLUS Waiver Items/Services

1. Applicant/Member Name	2. Medicaid No.
3. Name of Provider/Vendor contracted to perform completion/delivery of HCBS STAR+PLUS Waiver (SPW) item(s)/service(s):	
4. Specify the HCBS SPW item(s)/service(s):	5. Completion/Delivery Date:

This certifies that the HCBS SPW item(s)/service(s) were completed to the satisfaction of the MCO representative:

Signature – MCO Representatve _____ Date _____

This certifies that the HCBS SPW item(s)/service(s) were completed to the satisfaction of the member.

Signature - Member _____ Date _____